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THE BRITISH
JOURNAL OF DERMATOLOGY.

JUNE, 1911.

ACUTE LUPUS ERYTHEMATOSUS (AIGU D'EMBLÉE).

By LESLIE ROBERTS, M.D.,
Dermatologist to the Liverpool Royal Infirmary; Lecturer on Diseases of the Skin in the University of Liverpool.

Part I.—Clinical and Experimental.

Dr. Pernet, in 1908, published * an excellent clinical study of this rare form of Lupus erythematosus. He collected ten cases, carefully collating and analysing the symptoms. The case which I am now about to relate forms the eleventh of the series.

Elizabeth M—, aged 21 years, came under my care at the Royal Infirmary on June 23rd, 1910. When I first saw her, the face was swollen and suffused with a full deep red colour, symmetrically distributed over the cheeks, nose, eyelids, and ears. The outline of the reddened area was clear and sharp, and here the network of tortuous dilated capillaries was visible on close inspection. There was no crusting about the orifices of the follicles. The fingers were marked with symmetrical erythematous chilblain-like blotches. The special feature of the case was the intense hyperæmia, which was not confined to insular areas, but suffused over the face and ears.

Family history.—The patient is one of eight children, of whom two are dead. The mother is alive. The father died of "tuberculosis of the throat"; he had six brothers, all of whom are said to have died of consumption. Of the mother's family one sister is said to have died

* George Pernet, M.D., *Le Lupus Erythemateux aigu d'Emblée*, Paris M.D. Thesis.

of Bright's disease at the age of forty, but there is no history of tuberculosis.

History of the patient's present illness.—Up to November, 1909, the woman enjoyed good health. In November she began to feel tired, and complained of some difficulty in walking. Her throat felt sore and she had some difficulty in swallowing. She was unable to follow her employment. The diagnosis of quinsy was made by the doctor who saw her at that time. By the end of November she had sufficiently recovered to be able to resume her work. About April, 1910, she began to complain of aching pains in the arms and legs, and felt disinclined to work. In May an eruption appeared on both cheeks, and although the eruption increased week by week it would seem, according to the history, to have been limited for some time to the face. The pains in the limbs continued and interfered with sleep. She had no cough, but she frequently spat blood. On June 30th she was admitted into the Royal Infirmary as an in-patient. In the short interval which had elapsed since I first saw her the condition of her skin had changed much for the worse. The cheeks, the upper lip, the eyelids and ears were swollen and suffused with a purplish-red colour. On the cheeks were dark, greenish-yellow crusts, and beneath them the skin was ulcerated.

On the left cheek there was an ulcerated patch one inch long covered with a blood scab. There was marked enlargement of the capillaries of the face. Purpuric petechiæ were scattered over the chest, abdomen, and the upper and lower limbs, but they showed no tendency to grouping. The palmar surfaces of the fingers were marked with erythematous patches resembling pernio. The left big toe was erythematous. On the front of the chest was a patch 1½ in. in diameter, resembling a seborrhœic epidermitis. The temperature was 99° F. and the pulse 120.

July 1st.—Neither the urine or fæces show any visible signs of blood. There has been hæmorrhage from the ulcerated patches on the face, which are covered with dry blood scabs. The patient is getting 4 oz. of milk with 2 oz. of water and 1 drachm of brandy every two hours, and sulphate of quinine internally. She does not complain of pain.

July 2nd.—Temperature remains about 99° F. throughout the day.

July 3rd.—Bleeding from the mouth; some blood in the stools.

Complains of severe pain deep in the muscles of the right buttock, which prevents her from sleeping. Temperature rising all day, and by 6 p.m. is 103·4° F.; pulse 132.

July 4th.—The cheeks have lost some of their intense colour. The ulceration of the left cheek has extended at the margin. The black scab which covers it is depressed below the level of the surface. There are numerous dried blood-scabs on the cheeks, chin, lips, and on the edges of the nostrils. At 2 p.m. the temperature is down to 101° F., and the pulse is 124. At 10 p.m. the temperature is up to 103° F., the pulse is 112. The patient is deaf and there is discharge from both ears. There are no fresh petechiæ on the body. The right buttock is swollen and feels hotter to the touch than the left buttock, but the superjacent skin is pale. The erythematous purpuric patches on the finger-tips are tender, and look as if tending towards suppuration. The face is covered with a mask soaked in Liquor Burowii.

July 5th.—Complains of severe pain in the right forearm and on the back of the right hand. By 10 a.m. the temperature had dropped to 100·4° F., and at 10 p.m. has risen to 104° F.; pulse 120. Morphia $\frac{1}{6}$ gr. injected hypodermically.

July 6th.—By 2 p.m. the temperature has risen to 105·4° F. The patient is being frequently sponged with tepid water, and has taken by the mouth 10 c.c. of horse-serum three times in the day. Further necrosis has taken place under the scabs on the face. There has been no further hæmorrhage from the mouth or nose. There is some blood in the stools. At 6 p.m. the pulse is 160.

July 7th.—At 2 a.m. the temperature is 105, the pulse is hardly perceptible. The body is being sponged frequently. The patient is conscious, but sinking. Death occurred about noon.

Dr. Frederick Wilson, my clinical assistant, to whom I am much indebted for help in the experimental part of this article, made a careful examination of the urine and especially of the blood.

Condition of urine on July 4th.—"The specimen was pale yellow, showing a deposit of mucus. The reaction was acid, the specific gravity 1012. Nitric acid and boiling revealed a distinct cloud of albumen. There was no sugar and no di-acetic acid. Blood was absent. A marked indican reaction was present."

The examination of the blood for micro-organisation.—"The Wassermann test was negative. Ten c.c. of blood were taken from the bend of the elbow on July 4th—that is, three days before death, and while the symptoms were fully developed. The blood was inoculated into various media, but they all remained sterile. The patient's serum did not cause hæmolysis of normal red corpuscles." I would draw special attention to this fact. In the two other cases in which the blood was examined for micro-organisms, namely Jadassohn's and Pernet's, negative results were obtained.

The examination of the stools.—"The stools were formed but tarry in colour. Microscopically they showed no deviation from the normal micro-organisms met with in the stools of healthy persons."

Post-mortem Report.

The autopsy was made by Dr. Ernest Glynn twenty-four hours after death. The body was well nourished, and showed the remains of scattered petechial hæmorrhages on the trunk and limbs. Deep incision into the gluteal muscles was followed by exudation of slightly blood-stained fluid.

Thyroid gland.—Weight $1\frac{3}{4}$ oz., and is separated from the isthmus; a little below is an accessory thyroid the size of a kidney bean.

Lungs.—These were normal except for three minute subpleural hæmorrhages.

Heart weighed 9 oz. and was normal.

Stomach and intestines were normal.

Liver was enlarged, flabby, and soft, and weighed 70 oz.; on section it appeared pale; the tissue was soft and showed signs of old perihepatitis. The pancreas was normal.

Mesenteric glands were the seat of old caseous tuberculosis; the largest was the size of a walnut. Some of the smaller glands showed signs of recent tubercle.

Spleen was soft and diffluent and weighed 11 oz. There was well-marked perisplenitis of old standing.

Kidney.—The left weighed 6 oz.; the capsules stripped off easily. The stellate veins were strongly injected. The kidney substance showed signs of cloudy swelling; the cortex was slightly diminished. The right kidney weighed 6 oz. and was similar to the left.

Bladder was normal and also the *uterus*. The right *ovary* showed signs of hæmorrhage.

Brain and spinal cord.—The examination of these organs was not allowed.

Inoculation of agar and broth were made by Dr. Wilson from the spleen at post-mortem, and all the tubes yielded a pure culture of streptococcus. A piece of skin from the left cheek, removed for microscopical examination, showed well-marked hæmorrhagic staining in the cutis.

Microscopy of Organs, by Dr. Wilson.

"*Kidneys* revealed an acute parenchymatous inflammation. There were a few masses of Gram-positive cocci scattered throughout the section, but there was no special reaction around the organisms.

"The liver showed cloudy swelling and contained masses of Gram-positive cocci, but, as in the kidneys, the contagious tissues showed no special reaction. The spleen contained masses of Gram-staining cocci, which were also found in the supra-renal glands. The thyroid and accessory thyroid were apparently normal. Sections of the *mesenteric glands* were examined for tubercle bacilli with negative results. The sections showed no sign of recent tubercle. Animal inoculations were not performed."

Microscopy of the skin.—A piece of skin from the left cheek in the near neighbourhood of the ulcer was removed at the post-mortem and examined by Dr. Wilson. "Microscopically the corium showed marked hæmolytic staining. The tissue was fixed in a mixture of alcohol, formol, and acetic acid, and was embedded in paraffin. Sections were stained with hæmatoxylin and eosin, van Gieson, polychrome methylene-blue and acid orcein.

"The vessels and lymphatics of the corium were dilated and accompanied by marked peri-vascular cellular infiltration throughout the corium, reaching its greatest intensity at the point where ulceration had occurred. The exudation consisted of mononuclear leucocytes, deeply stained by the reagents, of feebly stained connective-tissue cells, and of a few small and large plasma-cells. Many of the leucocytes showed that they had been acted upon by a virulent toxin. The cytoplasm of many of the cells had disappeared, leaving misshapened and fragmentary nuclei. The connective-tissue cells appear

to have offered greater resistance to the cytolytic poison. The reticular layer of the corium has a rarefied appearance, but the elastic tissue is persistent. The epidermis shows a very considerable degree of atrophy. The cones in sections examined had disappeared. The prickle-cell stratum was reduced to two or three rows of cells, which were œdematous, without prickles, and some of them tending to fuse together. In the region of the ulcer the granular layer had disappeared, together with the stratum corneum, while the other layers were indicated by feebly staining strands enclosing spaces containing fragmentary nuclei. Here and there, on the free surface, were round or oval cells, with granular cytoplasm, and swollen, deeply stained nuclei. They appeared to be rete cells which had resisted the cytolytic effects of the toxin."

"Masses of Gram-positive cocci appeared on the surface of the epidermis, and in the upper parts of the corium at the ulcerated spot."

Such, then, are the bare facts of the case. It is remarkable how many points of similarity exist between it and the previously published cases of acute Lupus erythematosus, d'emblée. Her sex agreed with that of all the recorded cases except Pernet's. The mysterious origin, the vague early symptoms, the rheumatoid muscular pains, the increasing weakness and loss of appetite was noted in Heath's case. Painful spots in various parts of the body, which was a marked feature in my case, was recorded also by Kaposi in the ninth case of his series. In Boeck's case pain was complained of on the left shoulder. In both Jadassohn's cases pain in the joints and muscle was recorded. The purpura and hæmorrhage which formed so marked a feature in my case have been observed before. One of Kaposi's cases was preceded by an attack of Purpura hæmorrhagica, from which the patient appeared to have recovered before the onset of the Lupus erythematosus. In one of Jadassohn's cases the eruption was accompanied by cutaneous hæmorrhages. As regards personal and family antecedents my patient appears to have enjoyed good health up to November, 1909. The origin of the disease was insidious. There is a marked history of tuberculosis on her father's side, for seven out of a family of eight are said to have died of pulmonary and laryngeal phthisis.

The cutaneous symptoms of the eleven cases which have now been

recorded present many points of similarity. In all the earliest cutaneous manifestations of the disease were in the face, thence descending more or less rapidly to other parts. In Short's case the disease appeared about the same time in the ears and fingers. In Kaposi's fifth case (Observation 2 in Pernet's series) the sequence is not given, but in all the other cases, including my own, the disease first showed its existence in the face, and was limited here for an appreciable time before descending to other parts of the body. The appearance of the disease in the face varies according to the degree of acuteness. According to Pernet, the early stage of the eruption in his case resembled acute impetiginous eczema until the scabs were removed, when the true nature of the disease was seen. When the face is much swollen and hyperæmic there is something about it which suggests erysipelas, and which led Kaposi to employ the expression *Erysipelas perstans faciei*.

The uniformity of likeness in the character of the eruption on the face in the series of eleven cases is very remarkable. The eruption begins in multiple symmetrical spots or patches, which, coming together, blend and fuse till the whole face assumes a deep, dusky red hue. The outline of the eruption is clear and well-defined, so that healthy and diseased areas are sharply separated. These, the elemental features, are in some cases masked or modified by accidents which are not to be regarded as essential. For example, exudation may rise or fall in quantity, and the features may be modified by bullæ or crusting. In my own case there was actual necrosis of tissue, and the hæmorrhage had given rise to numerous blood-scabs. Another point of similarity is the rapidity with which the hands participate in the disease. In not one of the series of cases did the hands escape. The character of the eruption on the hands is not so uniform as on the face, in some cases taking the form of bluish-red patches, in others that of a papular or even purpuric rash. The absence of distinctive characters is still more apparent in the eruption on the body and limbs. The eruption, according to Kaposi, in the early stages may resemble impetiginous eczema, squamous eczema, ringworm of the body, Syphilis maculosa, bromide folliculitis, or Erythema herpes iris. In my own case, in addition to the purpuric spots there was a patch upon the chest which resembled a dry inflammatory seborrheid. In one of Kaposi's cases (Observation 3,

Pernet's series) there were flaccid hæmorrhagic bullæ on the body; in another there were red, non-scaly patches on the chest and back. In Boeck's case the body was marked with crusted papules. A red papular eruption scattered over the thorax and abdomen was observed by Jadassohn. To sum up, in all these cases of acute Lupus erythematosus d'emblée the maximum eruption appears upon the head, chiefly the face, and next upon the hands. On the face the eruption, if we exclude certain accurate features, is more or less uniform in its symptomatology. But on the body the symptoms lose the marked character they present on the face, and become extremely multiform in different cases.

The course and mode of termination.—All the cases belonging to this group are characterised by elevation of temperature and rapid pulse. It is important to note the exact period in the history of the disease when the temperature begins to rise, but on this point we lack definite information. In my own case, when the patient was admitted, notwithstanding the fact that the cutaneous symptoms were well advanced the temperature was only 99° F. It was not until the third day, when hæmorrhage was taking place from the mouth and intestines, that the temperature began to rise, and that evening it reached 103·4° F. The rhythm of the temperature is marked, presenting a diurnal swing not unlike that of septicæmia. The altered innervation of the heart's action, as indicated by the rapid pulse, is also very remarkable and characteristic of this disease.

In all these cases of acute Lupus erythematosus the essential symptoms of the disease are sooner or later confused through collateral symptoms arising from the active inflammation of one or more internal organs. In Pernet's case there was lobar pneumonia. Kaposi's two cases were also complicated by pneumonia. In the case recorded by Boeck the autopsy revealed pulmonary and glandular tuberculosis. One of Jadassohn's cases terminated with fibrinous pneumonia and acute parenchymatous nephritis, but no pneumonia. Of the eleven cases now recorded all ended fatally, with the exception of one recorded by Jadassohn.

Part II.—Suggestions and an Hypothesis.

All varieties of Lupus erythematosus appear to fall into three groups:

(1) Chronic d'emblée, the chronic discoid form, occurring on the face and ears.

(2) Those forms which begin like the chronic but eventually become disseminated and may end fatally.

(3) Acute d'emblée, which are acute from the beginning and which end fatally in a few weeks or months.

In approaching so difficult a task as that of explaining the nature of Lupus erythematosus, the first stage in the problem is to determine whether these three classes of cases represent three different diseases or whether they are merely different manifestations of the same disease. And before we can do this we must fix rigorously on the essential phenomena of the disease, excluding all co-lateral symptoms and all accidental irregular features. Reduced to its simplest terms, Lupus erythematosus is probably the excretion of a toxin by limited areas of the skin followed by a cytolytic and erythematous reaction. It seems to me that no case can be proved to be one of Lupus erythematosus unless it gives evidence of ectasia in limited areas and of cell atrophy. Whether the disease bears a superficial resemblance to eczema, to psoriasis, to lichen, is not of any essential importance. The only point to decide is whether a cytolytic toxin is present—a toxin which acts first on the cytoplasm, and secondarily on the nuclei. If we can prove this the diagnosis is settled, but without this evidence we cannot logically conclude that any suspected case is true Lupus erythematosus.

Applying this test to the three groups of cases, I cannot see how we can avoid the conclusion that they are only different manifestations of one and the same disease. Take, for example, the necrotic reaction. It is met with in this three-group series in all degrees of intensity, from the finest, almost microscopic interstitial scarring up to the actual necrosis and breach of surface continuity, as illustrated in the case which I have just recorded. We note also the same gradated variations in the hyperæmia, from mere tufts of telangiectases up to livid erysipelatoid redness and congestion. I think the most natural explanation of these variations is afforded by the assumption that they are caused by variations of the dosage of the poison.

The nature of this poison has so far eluded discovery notwithstanding the number of able workers in the field. Every dermatologist is aware of the high frequency with which Lupus erythematosus and

tuberculosis in one or another of its many forms coincide either in the same patient or in the same family. Thus Sequeira and Balean found that the disseminated variety of Lupus erythematosus was associated with the presence of tubercular disease in not less than 70 per cent. of their patients, and the discoid variety in 18 per cent. They also found a history of tuberculosis in the family in no fewer than 80 per cent. of their cases.* Boeck found evidence of actual or anterior tuberculosis in thirty-five out of fifth-three cases of the discoid variety.† It is this frequency of association between the two types of diseases that has led many to conclude that Lupus erythematosus is a toxi-tuberculide (Hallopeau), the toxin being tuberculin.

The coincidence of Lupus vulgaris and Lupus erythematosus in the same patient was first recorded, if I remember rightly, by Ludwig Nielson, but recently a similar case has been under my own care. The patient is a lady, aged 25 years, who is suffering from tubercular glands in the neck, Lupus vulgaris of the face, and Lupus erythematosus of the fingers. The lupus of the face is asymmetrical while the Lupus erythematosus is perfectly symmetrical. I have also under my care at the present time a brother and a sister. The former suffers from pronounced Lupus erythematosus of the so-called sebaceous type occupying the face and ears. The sister is affected with Lupus vulgaris of the nose. I need not enlarge further on the association of the two diseases, as every dermatologist is ready to admit it. The difficulty is to rightly interpret the facts.

There are not a few able thinkers who do not agree with Boeck that tuberculin is the toxic agent in the production of Lupus erythematosus. James Galloway‡ and MacLeod conclude from their researches that Lupus erythematosus is a manifestation of toxæmia more closely related to Erythema multiforme than to tuberculosis, and that the difference between the two diseases is one of degree rather than of kind. Pernet, in the monograph to which I have so often had occasion to refer, admits that we do not know the essential cause, and that possibly the disease is derived from more sources than one. Sequeira and Balean, after carefully weighing the evidence, con-

* Sequeira and Balean, *Brit. Journ. Derm.*, 1902, p. 367.

† Boeck, "Les Tuberculides," *Comptes rendus XIII Congres International de Medicine*, Paris, 1900, p. 107.

‡ Galloway and Macleod, *Brit. Journ. Derm.*, vol. xx, 1908, p. 65; also *ibid.*, vol. xv, p. 81.

clude that tuberculosis is not the actual determining cause of Lupus erythematosus. With this opinion I entirely agree, for the reason that the bacillo-toxins of tuberculosis do not possess the cytolytic properties so characteristic of the toxin of Lupus erythematosus. When the skin is invaded by tubercle bacilli the action of the generated tuberculin on the epithelium is exactly the reverse of that of the toxin of Lupus erythematosus. It may be doubted, indeed, whether tubercle bacilli ever of themselves lead to ulceration of the skin, and when this occurs it is probably due to the co-operation of other organisms such as streptococci.

This conclusion that the bacillo-toxins of tuberculosis are not the exciting cause of Lupus erythematosus by no means disposes of the vexed question of the relation subsisting between the two types of disease. For that some relationship does exist, I think, is clearly shown by the evidence. We need more light before we can define the relationship. When we test the relationship between Lupus erythematosus and tuberculosis of various organs of the body it becomes apparent that there is no connection between this disease and pulmonary tuberculosis. The statistics of our large consumption hospitals are proof of this. The relationship probably only comes into play when certain organs of the body are attacked by the tubercle bacilli. The researches of Boeck seem to indicate that these special organs are the lymphatic glands. He affirms that twenty-nine out of thirty-five patients suffering from Lupus erythematosus presented swollen glands or visible traces of pre-existing glandular disease. Of the eleven cases of Lupus erythematosus, acute from the beginning, we note in Pernet's case that the femoral and inguinal glands were enlarged, while the retro-peritoneal glands were tuberculous. In Kaposi's three cases no mention is made of the glands. In Boeck's case there was caseous degeneration of the retro-peritoneal glands. Franz Kock records marked swelling of the lymph-glands, especially in those of the neck. In Jadassohn's first case he noted œdematous swelling of the bronchial glands. His second case was also accompanied by slight pre-auricular and cervical adenitis. Sidney Short observed general enlargement and induration of the lymph-glands. After death some of them were found to contain pus. In Heath's case no mention is made of the condition of the glands. In my own patient we found old and recent tuberculosis of the retro-

peritoneal glands. Thus, in all the eleven cases, save four, where the authors are silent as to the condition of the lymph-glands, we have evidence of lymphatic disease.

Now, while we cannot admit that Lupus erythematosus is a manifestation of tuberculosis or of tuberculin poisoning, we are met by the fact that the disease is more frequently associated with adenitis than with any other morbid antecedent, and that this adenitis is very often of a tubercular nature. We need more light before we can explain the exact nature of the relationship. But while positive information is lacking, it sometimes happens that an hypothesis, or even a suggestion, may lead to fruitful discovery. It is at least conceivable that the cytolytic toxin of Lupus erythematosus is derived from the leucocytes in the lymph-glands, and that the formation of the toxin, although not absolutely dependent on the presence of tubercle bacilli, is favoured by the presence of the bacillus in the gland.

But no true or just conception of the nature of Lupus erythematosus is possible if we forget that the disease is really one of latitude and longitude. The geographical distribution is remarkable, for the nearer we approach the tropics the rarer becomes the disease—a distribution, by the way, which does not correspond with lupus or actual tuberculosis. Castellani, Chalmers, and Prout, all of whom have large experience in tropical diseases, agree as to the extreme rarity of the disease in tropical regions. Many dermatologists besides myself must have been struck at the extraordinary disappearance of the symptoms of Lupus erythematosus in patients who have resorted to the dry desert air of Egypt. These facts, together with those which have been recorded above, have led me to the conclusion that the primary source of Lupus erythematosus is a functional rather than an organic disturbance. From the first some depressant influence is at work tending towards lymph stagnation, and it is under this condition that I conceive the origin of the cytolytic poison in, or by, the leucocytes of the lymph-glands.

ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

A MEETING of the Dermatological Section of the Royal Society of Medicine was held on May 18th, 1911.

Dr. ADAMSON showed a (1) large *pigmented vascular sclerosing nævus* in a little girl, aged 10 years. The whole of the right lumbar region

FIG. 1.—Pigmented vascular sclerosing nævus.

was occupied by a large oval, reddish-brown patch, measuring 8 in. by 6 in. At the central part of the patch was a white area measuring 4 in. by 3 in. By firm pressure with a glass the colour of the patch could be pressed out, leaving the skin white, like that of the central part. The skin occupied by the patch was thickened and leathery, like that of scleroderma. The child was in good health; she was the tenth child, and there were no marks on the other children. She was born with a slightly raised black mark on the right flank, about 3 in. by 1½ in., and with its long diameter running parallel with the ribs. The black patch had gradually become white, and at four years of age the white area had become surrounded by a red ring, which

FIG. 2.—Pityriasis rubra pilaris. Showing the characteristic follicular papules on the trunk.

FIG. 3.—Pityriasis rubra pilaris. Showing the scaly condition of the face and palms.

had increased in size, and which continued to grow. The white area at the centre of the patch suggested that some caustic might have been applied, or that some ulceration had occurred; but this had not been the case.

Clinically, the patch suggested a patch of scleroderma, but the history was in favour of its being a nævoid growth.

Mr. McDonagh had kindly made a microscopical examination. A piece was removed from the lower margin of the patch. Histological examination showed (1) a marked increase in pigment, confined to the basal-cell layer of the epidermis; (2) in the corium numerous newly formed blood-vessels, without any sign of inflammatory cell exudation; (3) a dense connective tissue, made up of spindle-shaped connective-tissue cells; (4) a sparseness of elastic fibres. There were no cells of the pigmented mole type, and the pigment was confined to the epidermis, not to the corium, as in a pigmented mole.

The histological findings showed that the lesion was a growing vascular nævus, with rapid formation of new fibrous tissue.

Dr. Adamson was indebted to Dr. Horton Smith Hartley for allowing him to show the case.

(2) A case of *Pityriasis rubra pilaris* in a little girl, aged 5 years. The patient had been under the exhibitor's care nine months ago for an eruption, which was then diagnosed as follicular psoriasis. The diagnosis of Pityriasis rubra pilaris had been thought of at that time, but many of the characteristic features of that affection were absent, and the follicular eruption had been followed by a typical eruption of psoriasis. From this the patient became quite free after an attack of measles in November last. The present eruption was of one week's duration. It began as a redness and scaliness of the tips of the fingers; then the palms became red and scaly; then the folds behind the ears; red, scaly patches appeared on the knees; the neck and body became covered with small red follicular papules, and finally the face became red and scaly. The case now presented all the features of Pityriasis rubra pilaris. Almost the whole trunk and parts of the limbs were covered with firm red, pinhead-sized follicular papules. The face was red and scaly; the palms were red, and desquamating in large flakes; the follicles on the backs of the fingers were picked out characteristically

by small red papules; there were large red areas with thick scales on the knees, and scaly patches on the scalp. The only feature in which the eruption differed from a classical Pityriasis rubra pilaris was that the follicular papules did not present horny plugs, but showed silvery scales on scratching with the nail.

This case recalled a somewhat similar case in a child, aged $4\frac{1}{4}$ years, which was shown by Dr. Whitfield in 1902 (*Brit. Journ. Derm.*, vol. xiv, p. 470), in which the diagnosis between Pityriasis rubra pilaris and follicular psoriasis was discussed. In that case also the follicular lesion had a cap-like scale, and no central plug, and for that reason Dr. Whitfield had regarded the case as follicular psoriasis. Subsequently, in 1904 (*Brit. Journ. Derm.*, vol. xvi, p. 462), Dr. Whitfield had again shown the same case with the definite diagnosis of Pityriasis rubra pilaris.

Dr. Graham Little recalled an early case of his, shown to the Dermatological Society of London (*Brit. Journ. Derm.*, vol. xii, p. 92). The sister of this patient had been demonstrated to be the subject of psoriasis. He would also mention that in this case of Pityriasis rubra pilaris shown by him a few months ago, the application of an ointment consisting of salicylic acid ℈j and oil of cade ℥iij cleared the eruption after many other applications had failed.

(3) A case of *sporotrichosis* in a man who had lately been in Brazil, where he had got the infection. It was a classical case, with a chain of nodular swellings along the forearm. Cultures of sporotrichium (exhibited) had been grown from the lesions, and Mr. McDonagh had obtained a positive Wassermann reaction, using a sporotrichium culture as the antigen. Sections showed a granuloma with giant-cells.

(The case will be fully reported later in the *British Journal of Dermatology*.)

Mr. G. W. Dawson showed (1) a case of *extensive Lupus erythematosus associated with symmetrical gangrene* in a man, aged 49 years. The disease began last July, and now there were characteristic patches of the erythematous type on the face, ears, scalp, and back of hands and fingers. For some considerable time he had complained of his fingers going dead and white, actual necrosis had taken place at the end of the right little finger and the lower part of the helix of the right ear; besides these there were several small eschars on the back

of the fingers and a few on the nose, leaving slight scarring to mark their site.

Dr. Galloway said that it was unusual to find patches of necrosis of this type on the extremities in cases of Lupus erythematosus, but the course of this disease and the chances of septic infection of the extremities rendered it quite possible. He thought that it was not advisable to apply the term "Raynaud's disease" to this condition; it was especially to be observed that the tips of the fingers were not affected by the necrotic process. No doubt the term "Raynaud's disease" had become loosely applied, but the present case did not seem to him to warrant the diagnosis.

(2) A case of *fibromatous tumours* in a man, aged 55 years, who said he first noticed them at the age of twenty. They were very numerous, and varied in size from a walnut to a shot. They were distributed over the body, face, and limbs, but were more numerous on the trunk. The skin was freckled, and here and there were large patches of pigmentation.

Dr. Whitfield said a case was shown at the Dermatological Section a year or two ago in which great improvement was said to have occurred following the injection of fibrolysin. He would like to ask whether any member knew of further trial of this treatment, and, if so, whether any benefit had resulted.

Dr. F. Parkes Weber said he had tried fibrolysin in a typical case of the kind, and although the injections were not persisted in for long, he was convinced that it was of no use in the condition.* Even if some of the molluscous fibromata were to diminish in size under treatment by fibrolysin, no permanent benefit would be derived.

(3) A woman, aged 53 years, presenting *several patches of baldness on the scalp for the last three years.* They began as very small cicatricial-looking bare spots which gradually extended to form larger patches. The case was shown as one of pseudo-pelade, but some of the members did not agree with the diagnosis, and considered it Alopecia areata.

Dr. Pringle could perceive no signs of scarring, or of the typical circumpilar epidermic collarette round the hairs outside the bald areas, so that he could see no tangible grounds for the diagnosis of "pseudo-pelade."

Dr. Pernet said that in some of those obstinate cases of Alopecia areata he had seen good results from mercury internally. It had been his practice in that kind of case to exhibit mercury before the days of the Wassermann test, and he always looked for stigmata of syphilis. As to the name "pseudo-pelade," he did not think it was a good one: "cicatricial alopecia" was better.

* *Vide* F. P. Weber, "Case of Recklinghausen's Disease," *Proc. Roy. Soc. Med.*, 1910, vol. iii (Clinical Section), pp. 79–80.

Dr. Graham Little showed (1) a case of *Leucoderma syphiliticum* in a male patient, the subject of syphilis. The patient had contracted the disease about ten months ago; he had the scar of a chancre on the prepuce, and he had been seen earlier in the development of the disease with a well-marked syphilitic roscela. The leucoderma had been noted more recently, and was well marked on both sides of the neck. There was not at the present time any other manifestation of syphilis. The Wassermann reaction had been taken and had proved positive. The patient was of somewhat effeminate appearance, and it had been suggested by a colleague of the exhibitor that there might be an element of hermaphrodism in the case: the male organs were, however, quite normally developed, and this suggestion could not be sustained.

Leucoderma syphiliticum was an extremely rare event in a male: the exhibitor had never seen a previous case, and his colleague, Mr. Ernest Lane, whose experience of syphilis was exceptionally extensive, assured him that he also had never seen this condition in a male patient. No earlier eruption had been noted in the position where the present pigmentation was present, so that this was probably primary, not secondary, adopting the classification of Darier (*La Pratique Dermatologique*, article, "Melanodermie").

Dr. Pernet said he had seen several cases of the kind in males, and in two of them he noticed there were some of the secondary sexual characters of the female. Both these cases were seen at the St. Louis. The present patient was an effeminate type. Dr. Pernet had also had two other cases under his own care, one of them exhibiting a pigmentary syphilide of abdomen as well as of the neck.* One of these men he had demonstrated to the members of the Polyclinic. If the condition were looked for in a systematic way more examples of it would no doubt be observed.

Mr. Beddoes remarked that the condition was distinctly rare, and he had not seen it in any case in which there were not nits in the hair.

Dr. Pernet, in answering Mr. Beddoes, said he had seen the condition in women in whom there were no nits.

(2) A case of *Urticaria pigmentosa* of the macular type in a Jewish male infant, aged 8 months. The eruption had appeared for the first time when the child was seven weeks old, at first as a red rash, afterwards turning yellowish. There were now very numerous patches of disease on the chest, shoulders, back, abdomen, pubic region, thighs, buttocks, and calves of the legs; less thickly grouped on the scalp,

* See Pernet, "The Pigmentary Syphilide," *Brit. Med. Journ.*, 1909, vol. i, p. 184.

forehead, cheeks and neck. The hands and feet were quite free and no lesions were noted on the mucous membrane of the mouth. The glands in the neck and groin were notably enlarged. The eruption was not itchy. There were five other children, none of them similarly affected.

The lesions were a light yellow, changing to red on friction, and formed patches varying in size from that of a threepenny-bit to that of a shilling.

(3) A case of *Urticaria pigmentosa* (?) in an adult, a young woman, now aged 22 years. There was no itching anywhere. A Wassermann reaction had been done and proved negative; the hymen was intact and there was no history of syphilis.

A portion of a circumscribed pigmented lesion from the arm was excised and a report of the histology would be furnished later.

The exhibitor took the view that this was a case of adult Urticaria pigmentosa, and it strongly resembled another case reported by him (*Brit. Journ. Derm.*, 1905, Observation 13 of the personal series then recorded), also in an adult in whom there had been extensive diffuse pigmentation as well as circumscribed lesions of urticaria pigmentosa. The adult cases were exceedingly uncommon, but the exhibitor had collected notes of about twenty-two such up to 1905, and since that date other cases had been recorded, notably those of Bohac (*Brit. Journ. Derm.*, vol. xx, p. 18); of the exhibitor (*Brit. Journ. Derm.*, vol. xx, p. 232), a case in which a similar distribution in the forearms was noted; a case in an adult woman shown by Sir Malcolm Morris, the reference of which was not traced, at the Dermatological Society of London; a case shown by Dr. Eddowes in a man, aged 28 years, the eruption about eighteen months ago, merely as stains on the skin; there were no subjective sensations.

There were two types of pigmentation present in this case: (1) An extensive light brown diffuse pigmentation alternating in places with small areas of leucodermia, covering the whole back of the trunk from the neck to the buttocks and less deeply coloured on the front from the breasts to the pubes. Over the hips on both sides there were large irregular leucodermic patches and several smaller areas on the back. On this pigmented region there were no lesions like those of Urticaria pigmentosa except on the lower part of the abdomen, where there

were a few small, round, deeply pigmented areas the size of a small pea.

(2) Very numerous, much more deeply pigmented, circumscribed lesions, occurring almost exclusively on non-pigmented areas; the colour ranged from a deep red to a walnut-brown; the size of the lesions was uniformly small, of about a quarter of an inch in diameter, and the brown colour became suffused with red and the lesion turgid when scratched or rubbed. These lesions were distributed numerously over the shoulders, upper arms, on the anterior and posterior aspect, on the thighs and legs; a few were seen on the pigmented skin of the abdomen (*Brit. Journ. Derm.*, vol. xv, p. 296), and a case shown by Rutherford (*Brit. Journ. Derm.*, vol. xvi, p. 234), in which a diagnosis of syphilis had been altered to that of Urticaria pigmentosa on the authority of a histological examination of a lesion.

Sir Malcolm Morris said he showed a case of a middle-aged woman, who had the condition badly, and in whom it was still persisting. He did not arrive at a diagnosis until he had seen her several times.

Dr. G. Norman Meachen showed a case of *sycosiform syphilide*. The patient was a printer, married, aged 38 years. He stated that about four months ago a small place "like a corn" appeared upon the left palm, which gradually ulcerated, but was never painful. Six weeks ago he noticed "sores" upon the chin and face, also painless. There was no history whatever of any primary disease, nor were there any lesions inside the mouth or throat. On examination there was a shallow ulcer the size of a sixpence, situated upon the ulnar side of the left palm, while upon the chin, upper part of the neck, the eyebrows, and the upper lip were scattered papillomatous, vegetating lesions, hardly justifying, perhaps, the appellation "framboesiform," but more truly sycosiform in character: they did not discharge, and were painless. The blood gave a strongly positive Wassermann reaction (original method). The tendency towards the localisation of framboesial lesions in syphilis to the head and face was a point to which attention had been previously drawn by Dr. Galloway (*Brit. Journ. Derm.*, vol. xv, p. 209). It was also interesting to note that in a case of this type of syphilide, shown by Dr. Graham Little before the Dermatological Society of Great Britain and Ireland, in 1905, a localised patch of hyperkeratosis was present upon the right palm. In

the present case there was a small hyperkeratotic patch over the left thenar eminence, and also a similar area upon the right palm.

Dr. Pringle's experience was that such "sycosiform" and "framboesioid" syphilides occurred usually within the first few months of the disease, and were indicative of a very malignant type of infection, two of his cases having developed severe cerebral symptoms (? meningeal). They were of especial frequency on the scalp and face; and in no class of case did the *immediate* superiority of salvarsan over treatment by mercurials seem to him more striking. Despite the apparently immense destruction of tissue the amount of resulting scar was often quite trifling.

Dr. Whitfield pointed out that in this case the lesions were almost entirely confined to the hairy regions of the eyebrows, cheeks, and chin. He considered that this was an exaggerated form of syphilitic folliculitis or "sycosiform" syphilide, which was sometimes very difficult to distinguish from true staphylococcic sycosis. He agreed with Dr. Pringle that framboesiform syphilides, when present, were especially common on the scalp.

Dr. Galloway remarked on the unusual characters of the eruption, and thought that the peculiar features were due principally to the fact of the larger hair-follicles of the face and neck being involved; the eruption appeared to be a sycosiform rather than a framboesiform syphilide. Occasionally syphilis did produce a widespread eruption which closely resembled yaws, but in this country it was exceedingly rare. One very characteristic case had been under Dr. Galloway's observation and treatment. He considered the true framboesiform syphilide a feature of the earlier period of syphilitic infection in the so-called secondary stage. The case to which he referred occurred in a young woman who had a chancre on the lip followed by excessive and general enlargement of lymphatic glands. While the glands were thus affected large numbers of soft yaws-like lesions appeared over the whole body. The subsequent progress of the case was satisfactory.

Sir Malcolm Morris and Dr. Dore showed (1) a case of *acute Lupus erythematosus* in a girl, aged 21 years. The eruption was most severe on the upper part of the face, the cheeks being covered by large symmetrical, scaly, erythematous patches, with definitely outlined sinuous edges ending abruptly at the naso-labial groove on both sides, leaving the mouth, lips, and chin free. There were also scattered discrete smaller patches on the forehead and eyebrows. The scalp was seborrhoeic, but otherwise unaffected. On the back of the hands and fingers and on the palms there were small, slightly raised patches of a bluish tint and of circinate or irregular shape. The soles of the feet, the toes and heels were similarly affected, and a few small lesions had recently appeared on the elbows and knees. The eruption was accompanied by slight itching and considerable œdema of the face.

The condition began in February, 1911, and was preceded by severe chilblains during the winter. The patient attributed her illness to standing on a cold stone floor for many hours every day. Her family history was good, eleven brothers and sisters being healthy. She suffered from dysmenorrhœa and mental depression, but was otherwise healthy. There was no albumen in the urine. A special point of interest was the polymorphic character of the lesions on the hands; when the case was first seen some were like Lichen planus, some like psoriasis, and others like Erythema multiforme.

Dr. PERNET said there was no doubt in his mind as to the case being one of Lupus erythematosus. In connection with these disseminated forms, he mentioned the rare psoriasiform Lupus erythematosus, an instance of which he had under his care. Lupus erythematosus might imitate various rashes.

(2) A patient, aged 69 years, who had been invalided home after the Afghan War, in 1882, covered with Scinde ulcers, and now presented *extensive scarring of the face and limbs, and a pustular eczematoid eruption on the legs of dubious character.* He had also suffered from eczema, malaria, mitral disease, and an enlarged liver after the Burmah War in 1887. In 1901 he had lead poisoning, followed by gout, and the formation of large inflamed tophi on the finger-joints. An examination of his blood had given a positive reaction to Wassermann's test, and it was thought that this might throw some light on the pathology of Scinde ulcers.

(3) A young lady, aged 34 years, who had suffered from a *chronic lichenoid eruption* on the chest, shoulders, nape of neck, and flexor surfaces of the arms and legs since the age of fourteen. In some parts of the body the lichenification was diffuse; in others it took the form of patches, either pale or erythematous, resembling parapsoriasis. On the thighs and legs the patches were circular in shape. There was no thickening and very little itching. The patient's general health was good with the exception of occasional slight dyspepsia. The case was considered to come under the category of the "erythrodermias."

(4) A case of *tylosis* in a female, aged 49 years. The skin of the palms and soles presented excessive thickening, which terminated abruptly in a clearly defined erythematous margin resembling that of

Erythema keratodes. The thickening was, however, congenital, and had not changed during the twelve years she had been under observation. A peculiarity of the case was a remarkable contraction and tapering of the fingers, which approximated to the position of the "*main en griffe*." The patient was obese and neurotic, but enjoyed good health. It was doubtful if there was any atrophy of the thyroid. There was no history of the condition being hereditary.

Dr. GEORGE PERNET showed a coloured drawing of *nodular Lupus erythematosus*. At the last meeting a question had been asked as to what the late Dr. Radcliffe-Crocker meant by nodular Lupus erythematosus. Dr. Pernet was able to bring before the Society a coloured drawing from a case under the late Dr. Radcliffe-Crocker. The patient was a married woman, aged 27 years. The first lesion appeared at the age of sixteen on the right cheek. There was only one spot for the first two years; then others formed on the side of the nose. When first seen, the lesions were scattered irregularly over the side of the face, but with the exception of a hemp-seed-sized nodule on the left ear, there were none anywhere else. The lobes of both ears were atrophied-looking, but, according to the patient, there had never been any lesions on them. All the lesions were exactly like Erythema tuberculatum, and varied from a hempseed to half-an-inch in diameter, quite smooth, except one on the side of the nose, which was scaly. They were of a uniform purplish-red, except one, which was white in the centre. The general health was fairly good. The patient had had four children, and three premature pregnancies, once at six months and twice at seven months. One of the children had died of "consumption" of the bowels. Her paternal grandfather died of phthisis.

Note by Dr. Pernet.—The diagnosis of this condition must be made by taking the various factors as a whole: duration, appearance and behaviour of the individual lesions, and so forth. The late Dr. Radcliffe-Crocker noted the great resemblance to Erythema tuberculatum in this case. As pointed out by him, the lesions may simulate Lupus vulgaris at first sight.*

Dr. PRINGLE referred to two cases which he had diagnosed as examples of the nodular type of Lupus erythematosus, his opinion having been confirmed by

* H. Radcliffe-Crocker, *Diseases of the Skin*, vol. ii, p. 761, where the nodular form of Lupus erythematous is dealt with.

the old Dermatological Society of London. Both occurred in women about twenty-five years of age, and in both the subsequent progress proved that they were aberrant examples of Lupus vulgaris. A third case had been fully recorded by Dr. Liddell, of Harrogate (*Brit. Journ. Derm.*, vol. xii, 1900, p. 319), in which he had fallen into a similar error.

Dr. Sequeira showed *two cases of leprosy.*

Case 1.—A man of colour, born in Lahore, who had been in England for the past six years, and who described his occupation as a "hawker." He had smallpox when he was a year old, but had no illness until two years ago, when he began to suffer from a nasal discharge. The discharge was sometimes tinged with blood. About the same time he noticed that there was some thickening of his eyebrows, and sores appeared upon his left foot.

On admission to the London Hospital there were nodular thickenings the same colour as the skin over the supra-orbital ridges, and at the root of the nose. There were small swellings also upon the lobules of each ear. The nasal cavities were ulcerated and covered with dirty crust, and in the discharge Hansen's bacillus was demonstrated. The skin of the trunk was unaffected, that of the hands was shiny and smooth, and on the dorsal aspect of each forearm on the ulnar side there were rounded patches of pigmented skin about 2½ in. in diameter. These areas and the surrounding skin were anæsthetic. The ulnar nerves were markedly thickened.

On the sole of the right foot over the metatarsophalangeal joint there was a deep ulcer, which discharged a thin pus. The toes of the right foot were claw-like. On the right leg above the ankle there were several large patches of pigmented atrophic skin, which the patient said followed burns. On the left leg there were anæsthesic patches which corresponded mainly with the distribution of the peroneal nerves. The knee-jerks were present on both sides. The nails on both feet showed atrophic changes. There were opacities in each cornea which the patient stated were caused by ulcers which occurred when he had the smallpox. There were numerous variola scars on the face and elsewhere.

The Wassermann reaction was positive.

Case 2.—The patient was a white man, aged 44 years, a steward upon a mail boat. He had been at sea since he was a boy, and had been frequently to the Far East and India, but had never been

ashore for more than a fortnight at any one time. Upon the liners in which he was employed there were always coloured seamen—Lascars and Somalis—but it did not appear likely that he contracted the disease from them.

Four years ago a spot appeared upon his left arm. He was very indefinite about this initial lesion, but succeeding this there appeared at intervals blisters, which first arose upon the right elbow and hand. The blisters burst, leaving depressions upon healing. Gradually an eruption appeared all over the body, and when the patient was shown at the meeting there was a characteristic gyrate and ringed eruption upon the trunk, back and front. Some of the rings were an inch across, and others were 3 in. in diameter. The margins of the rings were red and definitely infiltrated, varying in width from a quarter to a third of an inch. The centres of some of these rings were anæsthetic, and sensation appeared to be delayed in others. The eruption itched somewhat, and in parts was slightly scaly.

Three months ago a sore appeared upon the inner side of the foot over the base of the fifth metatarsal bone. It had the characters of a perforating ulcer, and there was very little pain attending it.

The interossei muscles of the right hand were wasted, and the hand had begun to assume the claw aspect. Both ulnar nerves were thickened. The sensibility of the right hand on its inner side and dorsum was subnormal, but not completely absent. The patient complained of numbness in that hand. There has been very little discharge from the nose; the eyes were described as being weak, but the patient stated that they had always been so. Both knee-jerks were present.

The Wassermann reaction has since been examined and was found to be negative.

It is hoped that a further report upon the cases will be made when there has been a more complete examination. Dr. Sequeira proposed trying the influence of small doses of salvarsan.

Dr. Whitfield showed *a series of ringworm cultures*, illustrating the eczematoid ringworm of the hands and feet,

(1) A culture derived from the eruption on the hands and feet of a gentleman who had suffered from the eruption on the feet for eight years. It was interesting that two of his brothers had suffered

from similar eruptions on the feet for about the same time, and the disease had therefore been diagnosed as a hereditary family affection.

In all probability the disease was started as an attack of "Dhobie itch." One brother was in the Army, and had developed the disease while in India. He then came home, and the present patient thinks that it was while the soldier brother was staying at home that he developed it. The third brother did not live at home, but Dr. Whitfield had seen him, and had discovered the fungus between his toes, so that it was a natural inference that he had caught it in some way or other from one of his brothers. The culture developed into a slightly buff mound, of rather coarsely woolly appearance, and when it had grown to some size developed a rudimentary crater in the centre, which was not, however, very well marked.

(2) Another culture from a case, material from which had been kindly handed to Dr. Whitfield by Sir Malcolm Morris. In this case the disease had certainly started as a groin ringworm, the toe infection being distinctly later. A further point of interest was that the toe-nails were affected in two instances in this case. The culture was absolutely identical with No. 1.

(3) A culture from a recently developed groin ringworm, which was apparently contracted in South Africa. This culture was again absolutely similar to the two previous ones.

(4) A culture obtained from a ringworm of the scalp, in which the clinical symptoms and the method of attack of the hair were undoubtedly those of the endothrix. This culture was older and larger than the other cultures, but it had the same buff colour, and showed the same central shrinkage, forming a sort of ill-developed crater.

The exhibitor believed that the fungi in all these cases were identical, and would class them all as endothrix trichophyta.

(5) A sub-culture of Sabouraud's Epidermophyton inguinale to compare with these. The fungus was brought to Dr. Whitfield by Dr. Molesworth, and came from Sabouraud's laboratory. There was therefore no question as to its authenticity. It grew as a very flat and rather silky-looking culture, showing concentric rings like the markings on the cross-section of a branch of a tree. There was no marked folding in the centre, but merely shallow radiating lines such as one sees in the *Microsporon Audouini*. Dr. Whitfield said that he thought this was a distinct fungus from the others.

Dr. Adamson said that he had recently seen four cases of eczematoid ringworm between the toes. In two of these cases there was a history of ringworm of the groin some months before, and in one case ringworm of the groin was still present. He had found it difficult to obtain cultures of the ringworm fungus from the toes, but exhibited a culture from a recent case which closely resembled the cultures shown by Dr. Whitfield. He was not convinced that Dr. Whitfield's cultures were endothrix ringworm, but thought they corresponded with Sabouraud's cultures of *Epidermophyton inguinale*.

Sir Malcolm Morris said that a man came to him yesterday with an acute inflammation of the hands and feet: there were large scaly bullæ, and a fungus was found. The very valuable work which had been done in this connection by Dr. Whitfield would make clearer the conception of the nature of supposed dysidrosis between the toes. It was the fourth attack in his case, and it was regarded as dysidrosis. One of the causes of relapses in schools was that many still continued the habit of omitting to wear drawers. He had seen unquestionable instances of the infection from this custom. It was particularly the case in one public school.

Dr. Graham Little had seen, two years ago, when the distinction now made had not been ascertained, a case in a medical man of a "ringworm" of the groin and an "eczematous" eruption of the toes: mycelium had been demonstrated in both positions. The history was that the medical man had taken over rooms previously occupied by an *attaché* at the Turkish Embassy. The eruption proved very resistant to treatment.

Dr. Whitfield, in reply, said that one of his patients was a Turkish bath attendant, and another a girl who frequented Turkish baths. The two patients did not go to the same baths. He thought in these instances the disease was probably caught from the floor of the baths.

REVIEWS.

The Medical Annual.*

We are glad to see that this well-known annual pursues its successful course. This is the twenty-ninth year of publication, and in the preface the editor says he is thankful that it is edited and printed by those who were responsible for its first volume. We can well believe it. Of dermatological interest there are some excellent articles on skin-diseases by Graham Little, giving a well-thought-out epitome of the diseases and their treatment. It is a little curious, however, to note that the book should be filled out with an account of such rare diseases (in Great Britain) as yaws. The volume already contains more than two hundred pages of advertisements, which is no doubt satisfactory to the publishers, but adds greatly to the bulk of the book. For descriptions of rare diseases the practitioner might surely consult special text-books.

J. L. B.

* *The Medical Annual*. Bristol: John Wright & Sons, 1911. Pp. 991. Price 8*s*. 6*d*. net.

An Introduction to Dermatology.*

The fact that this book has reached its fifth edition renders it unnecessary to comment on its value to the student.

The arrangement of the subject-matter remains the same as in previous editions, but some of the newer work has been incorporated in it, and numerous very excellent coloured plates have been added.

There seems to be a little more in the book than previously, but the descriptions remain very concise and clear, and it is certainly an extremely readable text-book, and one calculated to leave a good impression on the mind of the student.

Certain points strike one as curious, some as being out of date and others as due to peculiar experience.

In the former class one may draw attention to the complete absence of scale staining as a method of diagnosis in diseases other than the moulds. Apparently it is owing to this that Dr. Walker still holds the opinion that psoriasis and seborrhœic eczema are one and the same process, and that he still has difficulty in the diagnosis between seborrhœic eczema and Pityriasis rosea. Also the valuable method of scale examination in Paget's disease is omitted. This strikes one as the more peculiar because a considerable space is devoted to describing the method of staining ringworm in the hair—a somewhat complicated procedure seldom used for diagnosis. No mention is made of Adamson's method of applying the X-rays for ringworm of the scalp, and this is an important omission, as the method has converted an appallingly difficult proceeding into one that is comparatively simple.

The statement that ichthyosis does not usually affect the palms and soles strikes one as peculiar, since it is common to suspect ichthyosis of the body by the appearance of the palms.

The histological illustrations generally are rather poor, especially fig. 1, which depicts deeply stained nuclei in the cells of the granular layer.

With these few exceptions the book is a valuable one, and it is in no captious spirit that allusion is made to them. It is pretty certain that further editions will be called for before long, and these criticisms are really rather in the nature of suggestions.

A. W.

Diseases of the Skin.†

This volume occupies a peculiar place in the literature of dermatology.

While not attempting to traverse the ground as completely as has been done by the authoritative works of the late Dr. Radcliffe-Crocker and others it is nevertheless a large book.

* *An Introduction to Dermatology.* By Norman Walker, M.D., F.R.C.P.E. Edinburgh: William Green & Sons. Fifth edition, 1911. Pp. x + 346; 43 coloured plates and 79 illustrations in the text. Price 12*s*.

† *Diseases of the Skin.* By J. H. Sequeira, M.D.Lond., F.R.C.P.Lond., F.R.C.S.Eng. London: J. & A. Churchill, 1911. Pp. xx and 539; coloured plates, 44; other illustrations, 179. Price 25*s*.

It has also a special feature in its wealth of illustrations, which are noticed below.

The book begins with a short article on the normal anatomy and the functions of the skin, and this is followed by a clearly written chapter on the morphology of the eruptions.

The various diseases are then grouped as far as possible according to their ætiology—undoubtedly the ideal method were it not that it leads to assumptions, the truth of which is not yet conclusively proved. It comes as a surprise to find Vernix caseosa described under diseases due to microbic infection and Furunculus orientalis under diseases due to spirochætes. It is true that on consulting the text one does not find that the former is believed by the author to be due to a microbe or the latter to a spirochæte, and these instances are only given to show the difficulties which arise from this method of classification.

In the article on eczema, which is extremely terse and clear, I note that Dr. Sequeira does not hesitate to use the pruning knife boldly and to exclude all the infective forms of dermatitis. It is, I think, still open to question whether this is entirely justifiable, as it certainly appears that a septic condition may either start or keep up a process clinically and microscopically indistinguishable from eczema, and it is quite certain that the dermatitis on the backs of the knees shown in fig. 25 and that shown on the breast in fig. 26 are infective conditions. The treatment of eczema is excellently expounded and the whole subject is treated with a common sense which is very refreshing.

In the article on ringworm three points struck me. First, the statement that ringworm of the nails is a rare affection. Now I am convinced that this is not the case, and Cranston Low has recently demonstrated the fact that ringworm of the nails is not uncommon.

Secondly, it is stated that the fungus of ringworm of the nails is generally the endo-ectothrix. As a matter of fact I believe every published case, at all events in this country, has been due to the endothrix with the exception of the cases of unknown fungus in Cranston Low's monograph and a single case of ectothrix of my own, and all these cases have been published probably since this volume was in the press.

Thirdly, I think Dr. Adamson's name rather than Kienböck's should have been associated with the modern method of radiotherapy of ringworm, since he brought the method down to its present very exact state as ably described in the work under notice.

In a book by Dr. Sequeira one naturally turns with eagerness to the article on lupus, and here we find him undoubtedly at his best. It is evident that he has an unusually complete familiarity with this formidable disease in all its phases, and the description of the treatment is done in a masterly manner.

Throughout the book Dr. Sequeira has evidently aimed at conciseness and in this he has succeeded completely. Occasionally, perhaps, one could have wished for a little more detail, but on the whole little is found to have been omitted.

With regard to the illustrations, which form a notable feature of the book, it may be said that the half-tone photographs are admirable almost without exception. The coloured plates are unfortunately not so successful. There is a prevailing tone of greenish-yellow, which to some extent destroys the faithfulness of the representation. A. W.

SEVENTH INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOLOGY, ROME, 1911.

Important Alteration of Date.

Dr. Ciarrocchi, the Secretary of the Congress, asks us to direct attention to an important alteration in the arrangements. To suit the convenience of many members the date of the Congress has been *put forward a week*. It will be held from September 18th to 23rd, 1911, instead of from the 25th to 29th.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

ERYTHEMAS, INFLAMMATIONS, ETC.

Acne Rosacea and the Sebaceous Glands. Rommel. (*Monthly Cyclopædia and Med. Bulletin*, Philadelphia, February, 1911, p. 94.)

Atrophia Cutis Idiopathica, Several Cases of. L. Török. (*Archiv f. Derm. u. Syph.*, cvii, 1–3, 1911, p. 215.)

Bullous Dermatitis, A Fatal Case of. S. Pollitzer. (*Journ. of Cut. Dis.*, vol. xxix, No. 4, April, 1911, p. 209.)

Chalky Concretions, Subcutaneous, and Sclerodermia. Thibierge and Weissenbach. (*Ann. de Derm. et de Syph.*, March, 1911, p. 129.)

Dermatitis Fibrinosa Faciei. Moro. (*Münch. med. Wochenschr.*, February, 1911, No. 6, p. 298.)

Ecthyma Gangrænosum. K. Groen. (*Archiv f. Derm. u. Syph.*, cvi, 1–3, 1911, p. 217.)

Eczema in Infants. Rocaz. (*Arch. de Méd. des Enf.*, vol. xiv, February, 1911, p. 81.)

Elephantiasiform Lesions, of Undetermined Nature, on the Labia Majora, Pseudo-sclerodermia of the Thighs, not Congenital. Eyrand Dechaux. (*Ann. de Derm. et de Syph.*, March, 1911, p. 169.)

Erythema Elevatum Diutinum and Granuloma Annulare. Dalla Favera. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. li, p. 236.)

Erythema Multiforme Iris during the Course of Typhoid Fever. H. P. Parker. (*Bull. of the Johns Hopkins Hosp.*, xxii, No. 240, March, 1911, p. 79.)

Erythrodermia Desquamativa in Nurslings (Leiner's Disease). S. Beck. (*Archiv f. Derm. u. Syph.*, cvi, 1–3, 1911, p. 9.)

Erythrodermia Desquamativa (Leiner), On the Position of. Moro. (*Münch. med. Wochenschr.*, March 7th, 1911, No. 10, p. 499.)

Exanthems after Vaccination in Children. Mathilde de Biehler. (*Arch. de Méd. des Enf.*, vol. xiv, February, 1911, p. 264.)

Herpes Zoster, Renal Colic, Head's Area and. Rosenberg. (*Deutsch. med. Wochenschr.*, April 27th, 1911, No. 17, p. 788.)

Hydroa Vacciniforme of Bazin, Contribution to the Knowledge of. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. lii, 1911, Fasc. 1, p. 89.)

Hysterical Necrosis of the Skin with Erythematous and Exudative Prodromata, On. Werther. (*Derm. Zeitschr.*, Bd. xviii, Heft 4, p. 341.)

Infectious Eczematoid Dermatitis, Possible Influence of Anaphylaxis in Skin Reactions. J. A. FORDYCE. (*Journ. of Cut. Dis.*, vol. xxix, No. 3, March, 1911, p. 129.)

Lupus Erythematosus, An Atypical Form of. G. NOBL. (*Archiv f. Derm. u. Syph.*, cvii, 1–3, 1911, p. 109.)

On Affections of the Skin in Pregnancy and their Cure. LUISER. (*Derm. Zeitschr.*, Bd. xviii, Heft 3, p. 217.)

On Skin-Eruptions in Myeloid Leucæmia and in Malignant Granulomatosis. BRUNSGAARD. (*Archiv f. Derm. u. Syph.*, cvi, 1–3, 1911, p. 105.)

Parapsoriasis en Plaques (Brocq), On the Occurrence and Diagnosis of. BOGROW. (*Derm. Zeitschr.*, Bd. xviii, Heft 2, p. 137.)

Peculiar Exanthem in Anæmia Pseudoleucæmia Infantum, A. F. JULIUSBERG. (*Archiv f. Derm. u. Syph.*, cvi, 1–3, 1911, p. 303.)

Pemphigoid Dermatitis, Chronic Pruriginous, with Periodical Recurrences in Relation with Amenorrhœa. VERROLLI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. lii, 1911, Fasc. 1, p. 32.)

Pemphigus, Traumatic, not Congenital, Localised on Scars. BLAZE. (*Ann. de Derm. et de Syph.*, March, 1911, p. 178.)

Pemphigus Vegetans, Historical, Clinical and Histological Study. C. CRONQUIST. (*Archiv f. Derm. u. Syph.*, cvi, 1–3, 1911, p. 143.)

Prurigo and the Papule with the Urticarial Basis. O. H. HOLDER. (*Journ. Cut. Dis.*, vol. xxix, No. 4, April, 1911, p. 228.)

Psoriasis treated by Arsenic, Melanodermia and Pre-cancerous Arsenical Keratosis. EYRAUD. (*Ann. de Derm. et de Syph.*, April, 1911, p. 236.)

Purpura and Tuberculosis, Subacute. P. HAUSHALTER. (*Arch. de Méd. des Enf.*, vol. xiv, May, 1911, p. 356.)

Purpura Hæmorrhagica, On the Pathogenesis of. S. CANNATA. (*Deutsch. med. Wochenschr.*, May 25th, 1911, No. 21, p. 985.)

Purpura, On a Peculiar Form of, with Cerebral Hæmorrhage. F. SCHMEY. (*Deutsch. med. Wochenschr.*, February 16th, 1911, No. 7, p. 307.)

Röntgen Erythema. BRAUER. (*Deutsch. med. Wochenschr.*, No. 12, 1911.)

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Sclerodermia with Cirrhotic Liver, On a Case of Generalised. ERCOLI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. li, p. 252.)

Sclerodermia with Hemiatrophia Facialis. A. AFZELIUS. (*Archiv f. Derm. u. Syph.*, cvi, 1–3, 1911, p. 3.)

Swine Erysipelas in Man, A Case of. LINSER. (*Derm. Zeitschr.*, Bd. xviii, Heft 4, p. 352.)

Toxic Papulo-pustular Rash after the Treatment of Acne with Rontgen Rays, A. SCHMIDT. (*Derm. Zeitschr.*, Bd. xviii, Heft 4, p. 348.)

Urticaria Pigmentosa in an Adult, Further Researches on a Case of. ERCOLI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. li, p. 250.)

Vegetating Eczema. GAVINI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. li, p. 607.)

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Diagnostic Value of Tuberculin, as shown by Nineteen Autopsies. MILLS. (*Med. Record*, March 25th, 1911, p. 532.)

Elephantiasis of the Leg of Tuberculous Origin (illustrated). GALLIARD and BAUFLE. (*Bull. et. Mém. de la Soc. Méd. des Hôp.*, April 13th, 1911, p. 437.)

Erythema Induratum Scrofulosorum, Treatment by Tuberculins. GEO. THIBIERGE and WEISSENBACH. (*Bull. et Mém. de la Soc. Méd. des Hôp.*, March 30th, 1911, p. 264.)

Erythema Induratum (Bazin) and their Relations to Tuberculosis, On Atypical Forms of. V. MUCHA. (*Archiv f. Derm. u. Syph.*, cvii, 1-3, 1911, p. 61.)

Lupus Therapy, Problems of. A. JUNGMANN. (*Archiv f. Derm. u. Syph.*, cvi, 1-3, 1911, p. 311.)

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Nodular Tuberculosis of the Hypoderm. J. W. WENDE. (*Journ. of Cut. Dis.*, vol. xxix, January, 1911, p. 1.)

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Tuberculosis in Lepers. H. P. LIE. (*Archiv f. Derm. u. Syph.*, cvii, 1-3, 1911, p. 3.)

Tuberculosis Verrucosa Cutis and Tuberculous Lymphangitis, the Result of Cattle Tubercle Infection, A Case of. HENSER. (*Deutsch med. Wochenschr.*, February 9th, 1911, No. 6, p. 260.)

Tuberculosis Verrucosa Cutis and Tuberculous Lymphangitis, the Result of Cattle Tubercle Bacillus (Remarks on the Work of Henser in *Wochenschr.* No. 6). B. MOLLERS. (*Deutsch. med. Wochenschr.*, March 16th, 1911, No. 11, p. 504.)

Tuberculosis Verrucosis Cutis, Case of. HENSER. (*Deutsch. med. Wochenschr.*, No. 6, 1911.)

Tuberculous Ulcer of the Right Nostril. THIBIERGE and WEISSENBACH. (*Ann. de Derm. et de Syph.*, February, 1911, p. 85.)

Ulcerative Tuberculosis of the Skin following a Wound of the Heel, with Tubercular Glands in the Groin, On a Case of. COPPOLINO. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. li, p. 457.)

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Blastomycosis, Systemic, Report of a Case. R. G. WASHBURN. (*Journ. Amer. Med. Assoc.*, April 15th, 1911.)

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Frambœsia, Case of. C. J. WHITE and E. E. TYZZER. (*Journ. of Cut. Dis.*, vol. xxix, No. 3, March, 1911, p. 138.)

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Leprosy, Symptomatology of. HOWARD FOX. (*New York Med. Journ.,* April 22nd, 1911, p. 712.)

Notes on Ulcerative Granuloma. S. JACKSON. (*Australasian Med. Gaz.,* March 20th, 1911, p. 133.)

Sporotrichosis in Man and in the Horse. R. L. SUTTON. (*Boston Med. and Surg. Journ.,* February, 1911, p. 179.)

Sporotrichosis. E. VON OFFENHEIM. (*Lancet,* March 11th, 1911, p. 659.)

NEW GROWTHS.

Epithelioma Planum, Cicatricial, of the Forehead. THIBIERGE and WEISSENBACH. (*Ann. de Derm. et de Syph.,* April, 1911, p. 233.)

Lymphangioma Circumscriptum of the Skin, A Case of. WEISSENBACH. (*Ann. de Derm. et de Syph.,* March, 1911, p. 173.)

Lympho-sarcoma, Ulcerated, of the Lip (or Atypical Sarcoma with Polymorphic Cells) resembling "Smokers' Cancer." DARIER. (*Ann. de Derm et de Syph.,* April, 1911, p. 226.)

Molluscum Contagiosum, Further Contributions to the Knowledge of. B. LIPSCHÜTZ. (*Archiv f. Derm. u. Syph.,* cvii, 1–3, 1911, p. 387.)

Multiple Idiopathic Skin Sarcoma with Metastases in the Joints. L. V. ZUMBUSCH. (*Archiv f. Derm u. Syph.,* cvii, 1–3, 1911, p. 329.)

Multiple Dermatomyoma (Myoma Cutis). E. KRETZMER. (*Archiv f. Derm. u. Syph.,* cvii, 1–3, 1911, p. 379.)

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Sarcoma, Fasciculated, of the Nose, Simulating Rhino-scleroma. DARIER. (*Ann. de Derm. et de Syph.,* April, 1911, p. 221.)

Xanthoma, Juvenile, On. BIZZOZERO. (*Giorn. Ital. d. Mal. Ven. e della Pelle,* vol. li, p. 445.)

Xanthoma Tuberosum, Disseminated and Generalised, with Considerable Hypercholesterinæmia. THIBIERGE and WEISSENBACH. (*Bull. et Mém. de la Soc. Méd. des Hôp.,* p. 393; April 6th, 1911, p. 359.)

AFFECTIONS OF THE HAIR AND APPENDAGES, AND PIGMENTARY CHANGES, ETC.

Alopecia, On a Case of Periodical. VIGNOLO LUTATI. (*Giorn. Ital. d. Mal. Ven. e della Pelle,* vol. ii, p. 227.)

Alopecia Areata, Traumatic. MARTINO. (*Giorn. Ital. d. Mal. Ven. e della Pelle,* vol. li, p. 583.)

Alopecia Areata, New Studies in Ætiology of. SABOURAUD. (*Ann. de Derm. et de Syph.,* February, 1911, p. 65.)

Alopecia Areata, Exposure to the Sun as an Ætiological Factor in. G. F. HARDING. (*Journ. of Cut. Dis.,* vol. xxix, No. 3, March, 1911, p. 164.)

Hypertrichosis Lumbalis without Spina Bifida. M. SCHEIN. (*Archiv. f. Derm. u. Syph.,* cvii, 1–3, 1911, p. 335.)

Hyperidrosis, Circumscribed, with Lesion of the Chorda Tympani. KURT HALBEY. (*Deutsch. med. Wochenschr.*, March 20th, 1911, No. 13, p. 587.)

Leucodermia of Psoriasis, A Clinical Contribution to. PETRINI. (*Ann. de Derm. et de Syph.*, March, 1911, p. 156.)

Leucodermia Syphiliticum, The Influence of Light on, and in Cutis Marmorata Pigmentosa. BUSCHKE and EICHHORN. (*Derm. Zeitschr.*, Bd. xviii. Heft 2, p. 109.)

Periadenitis Mucosa Necrotica Recurrens. R. L. SUTTON. (*Journ. of Cut. Dis.*, vol. xxix, No. 2, February, 1911, p. 65.)

Pigmentation, Researches on Post-mortem. R. WINTERNITZ. (*Archiv f. Derm. u. Syph.*, cvii, 1-3, 1911, p. 293.)

Pruritus Cutaneus Universalis. WINKLER. (*Monats. f. prakt. Derm.*, March 1st, 1911, p. 223.)

HYPERKERATOSIS.

Follicular Keratosis, A Case of. BOTTELLI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. li, p. 432.)

Hyperkeratosis and Universal Ankylosing Arthritis; Unusual Complications of Gonorrhœa. ROST. (*Derm. Zeitschr.*, Bd. xviii, Heft 3, p. 233.)

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Hyperkeratosis Striata et follicularis and Lichen ruber atypicus. CARL BRUCK. (*Archiv f. Derm. u. Syph.*, cvi, 1–3, 1911, p. 91.)

Ichthyosis, on Fœtal. MARIOTTI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. lii, 1911, Fasc. 1, p. 84.)

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NÆVI.

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Two Cases of Nævus Linearis Verrucosus Generalisatus vel Nævus Systematisatus, Histological Investigation of. HODARA. (*Monats. f. prakt. Med.*, April 1st, 1911.)

RINGWORM AND FAVUS.

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Ringworm, The Present Position of the X-ray Treatment of. S. E. DORE. (*Lancet*, February 18th, 1911, p. 437.)

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A New Method of Examination of Dermatoses—Methodic Curetting. BROCQ. (*Paris Médical*, March 4th, 1911, p. 322.)

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Some Problems of Metabolism Occurring in Patients with Certain Diseases of the Skin. L. DUNCAN BULKLEY. (*Journ. of Cut. Dis.*, vol. xxix, No. 4, April, 1911, p. 217.)

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The Value of Antiformin in Detecting Tubercle Bacilli in the Tissues. HART and LESSING. (*Wien. klin. Wochenschr.*, No. 9, 1911.)

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Leprosy Bacilli, Influence of Salvarsan on. MONTESANTO. (*Münch. med. Wochenschr.*, No. 10, 1911, p. 511.)

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Zinc Oxide in Face Powder. S. S. COHEN. (*New York Med. Journ.*, March 25th, 1911, p. 570.)

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A Case of Hereditary Syphilis. DE FAVENTO. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, vol. li, p. 520.)

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